DEPARTMENT OF HEALTH AND HUM 11 SERVICES PRINTED: 03/16/2016 CENTERS FOR MEDICARE & MEDICAL SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 445383 NAME OF PROVIDER OR SUPPLIER 03/09/2016 STREET ADDRESS, CITY, STATE, ZIP CODE HORIZON HEALTH AND REHAB CENTER 811 KEYLON STREET MANCHESTER, TN 37355 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX ID PROVIDER'S PLAN OF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION) **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) "This Plan of Correction is prepared and F 000 INITIAL COMMENTS submitted as required by law. By submitting F 000 this Plan of Correction, Horizon Health and Rehabilitation does not admit that the A Recertification survey and investigation of deficiency listed on this form exist, nor does complaint #38011 was conducted from 3/7/16 the Center admit to any statements, findings, through 3/9/16, at Horizon Health and Rehab facts, or conclusions that form the basis for the Center. No deficiencies were cited in relation to alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or complaint #38011, under CFR PART 483, administrative proceedings the deficiency, Requirements for Long Term Care Facilities. statements, facts, and conclusions that form the 483.35(i) FOOD PROCURE, F 371 basis for the deficiency." F 371 STORE/PREPARE/SERVE - SANITARY SS=F How the corrective action(s) will be 4-23-16 accomplished for those residents The facility must found to have been affected by the (1) Procure food from sources approved or deficient practice. considered satisfactory by Federal, State or local authorities; and The grill surface and the interior and (2) Store, prepare, distribute and serve food exterior sides of the grill were under sanitary conditions cleaned on 3/23/16. Improper food handling was immediately stopped upon observation after the 4th tray and the dietary cook was in-serviced by the This REQUIREMENT is not met as evidenced Dietary Manager on 3/7/16 to use gloves and/or tongs. Based on observation, interview, and review of the dish machine manufacturer's The sanitizer level of the dish recommendations, the facility failed to maintain machine was checked on 3/8/16. dietary equipment in a sanitary manner, failed to serve food in a sanitary manner for 4 of 10 trays The filter over the fryer was cleaned and failed to ensure the dish machine sanitizer on 3/23/16. level was within the manufacturer's The shelf under the preparation table recommendation level. was cleaned on 3/23/16. The findings included: Observation on 3/7/16 at 5:12 AM and on 3/8/16 at 8:35 AM, in the dietary department, and interview with the dietary cook present, confirmed the grill surface, and the interior and exterior ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

In the safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days as following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 rooram participation.

STATEMEN	T OF DEFICIENCIES	AND HUN SERVICES  & MEDICAL SERVICES  (X1) PROVIDER/SUPPLIER/CLIA	T <sub>(Y2)</sub> MIII TIE		FOR	D: 03/16/201 MAPPROVE O. 0938-039
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION	(X3) DA	ATE SURVEY OMPLETED
		445383	B. WING			
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS STREET	03	3/09/2016
	N HEALTH AND REHA		8	STREET ADDRESS, CITY, STATE, ZIP CODE B11 KEYLON STREET MANCHESTER, TN 37355		
(X4) ID PREFIX TAG	CACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	DE	(X5) COMPLETION DATE
F 371	371 Continued From page 1 sides had a heavy black accumulation of debris. Further interview revealed the grill was not used for cooking.  Observation on 3/7/16 at 6:35 AM in the dietary department, with the dietary manager present, revealed the resident morning meal tray line was in process. Further observation revealed the dietary cook serving the food, touching the biscuit, bacon, and orange slice with the same gloved hand for 4 of 10 trays, thereby possibly contaminating the food.		F 371	80 out 0	to	4.23-16
				All residents have the potential to affected.  On 3-8-16, sanitation strips were obtained and immediate testing beand sanitation strips are now being used with each dish cycle	gan	
-	touching 3 separate gloved hand.  Observation on 3/8/1	ok and dietary manager on infirmed the cook had been food items with the same		An Eco-lab technician initiated an service via phone conference on 3-16 on checking sanitization levels f the dish machine for dietary employees. This in-servicing was completed in person on 3/14/16 for all dietary employees.	8- for	
	with the dietary mana revealed the dish mana Review of the manufa posted on the dish malevel was to be at least chlorine. When the dishave the sanitizer level stated the chemical commachine monthly. Interime of the observation was new and in place months. Further interiand the cook, reveale and had not checked	acturer's recommendations actine revealed the sanitizer st 50 parts per million for etary manager was asked to el checked, the manager		Cleaning schedule is posted with daily and weekly assignments. Dee cleaning of the kitchen is done on a daily continuous basis.	p	

there were no test strips available to check it. Review of the chemical company monthly visit documentation revealed the sanitizer level was or

SIMIEMEN	IT OF DEFICIENCIES OF CORRECTION	& MEDICAL SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	LTIPL	E CONSTRUCTION C	OMB N	M APPROVEI O. 0938-039
		SERVIN IOATION NUMBER:	A. BUILD	DING_		CC	ATE SURVEY OMPLETED
WALE OF		445383	B. WING		-		
NAME OF	PROVIDER OR SUPPLIER	-	1		REET ADDRESS, CITY, STATE, ZIP CODE	03	3/09/2016
HORIZO	N HEALTH AND REHA	AB CENTER		81	11 KEYLON STREET ANCHESTER, TN 37355		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	DE	(X5) COMPLETION DATE
F 371	Continued From pay sides had a heavy b Further interview re- for cooking.	ge 1 lack accumulation of debris. vealed the grill was not used	F 3	71	3. What measure will be put in place or systemic changes made t ensure that the deficient practice will not recur.	to	4-23-16
	Observation on 3/7/department, with the revealed the resider in process. Further of dietary cook serving biscuit, bacon, and of gloved hand for 4 of contaminating the form of the contaminating the contaminating the contaminating the contaminating as separate of the couching 3 separate of gloved hand.	ok and dietary manager on infirmed the cook had been food items with the same			An Eco-lab technician initiated an i service via phone conference on 3-8-16 on checking sanitization levels for the dish machine for dietary employees. This in-servicing was completed in person on 3/14/16 for all dietary employees.  The Dietary Manager in-serviced 100% of dietary staff on the Preventing Foodborne Illness – Food Handling policy and procedure which included handwashing, using gloves, and tongs and this in-servicing was completed on 3-22-16.	8- for	
	with the dietary mana- revealed the dish ma Review of the manufa- posted on the dish ma level was to be at lea- chlorine. When the di- have the sanitizer level stated the chemical comachine monthly. Inte- time of the observation was new and in place- months. Further inter- land the cook, revealed and had not checked	of beginning at 8:27 AM in the dish room, and interview ager and/or cook present, chine was in operation. Acturer's recommendations achine revealed the sanitizer st 50 parts per million for etary manager was asked to be checked, the manager company checked the erview with the cook, at the in, stated the dish machine for perhaps the last 6 view with both the manager of the dietary staff did not the sanitizer level of the e machine's installation and			A Dish Machine Sanitization Log was developed and utilization of this log began on 3/9/16 to document compliance of sanitization testing of the dish machine. The Dietary Manager will document compliance 5x/week x 4 weeks, then weekly x 4 weeks, then monthly x 2 months to ensure compliance.  On 3/23/16, the grill surface and under the prep table were added to the dietary daily cleaning schedule and fryer filters were added to the weekly cleaning schedule.		

there were no test strips available to check it.

Review of the chemical company monthly visit

documentation revealed the sanitizer level was or

exceeded 75 parts per million. Interview with the

The Dietary Manager will document

compliance of safe handling of food

5x/week x 4 weeks, then weekly x 4

weeks, then monthly x 2 months to

DEPAR CENTE	TMENT OF HEALTH	AND HUM ' SERVICES			PRINTE	ED: 03/16/2016 RM APPROVED
STATEMEN	CENTERS FOR MEDICARE & MEDICA. J SERVICES  TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			O. 0938-0391 ATE SURVEY OMPLETED
NAME OF	PROVIDER OR SUPPLIER	445383	B. WING		1 0	3/09/2016
	N HEALTH AND REHA	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 811 KEYLON STREET MANCHESTER, TN 37355	<u> </u>	3/09/2016
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT	OULD BE	COMPLETION DATE
F 456 SS=F	facility Administrato hall outside the Dire revealed the dish manager proventhe grill had an food debris, and the had a greasy resiductook revealed the conthe shelf above that day. Further obthe manager confirm preparation table had debris present. Furting grill surface and extheavy accumulation 483.70(c)(2) ESSEN OPERATING CONDITION The facility must manager on the shelf above that day. Further obthe manager confirm preparation table had debris present. Furting grill surface and extheavy accumulation 483.70(c)(2) ESSEN OPERATING CONDITION The facility must manager on the same chanical, electric equipment in safe of the same and 3 of 3 wooperating condition.  The findings include Observation on 3/7/	r on 3/8/16 at 9:45 AM in the ector of Nursing office, eachine had been installed in 1/16 at 8:35 AM in the dietary erview with the cook and esent, confirmed the shelf accumulation of smeared efficer positioned over the fryer e. Further interview with the cook had not placed anything the grill while he was cooking servation and interview with med the shelf under the end rust and dried splattered ther interview confirmed the erior and interior sides had a for black debris.  NTIAL EQUIPMENT, SAFE DITION  Initiatin all essential al, and patient care perating condition.  It is not met as evidenced on and interview, the facility failed to maintain 1 of 1 plate walk-in refrigerators in a safe	F 45	deficient practice is being correwill not recur.  The Administrator of Dietary Mawill present the audit results to the monthly Quality Assurance Performance Committee (Membinclude: Committee Chairperson Administrator; Director of Nursing; Massistant Director of Nursing; Massistant Director of Nursing; Massistant Director; Pharmance Representative; Social Services Dactivities Director; Environmenta Director/ Safety Representative; Control Representative/Staff Development Coordinator; Rehab Director; and Medical Records Dactivities of Safety Representative (Staff Development Coordinator) and Medical Records Dactivities of Safety Representative (Staff Director) and Medical Records Dactivities of Safety Representative (Staff Director) and Medical Records Dactivities of Safety Representative (Staff Director) and Medical Records Dactivities Director (Safety Representative) and Medical Records Dactivities Dactivities Director (Safety Representative) and Medical Records Dactivities Dactivit	anager ne ormance oers - ng; edical nacy Director; al Infection oilitation oirector.) ondations will be ts found ficient on we rust 6. ingerator # on 3/21/16 ket was	4.23-16

DEPARTMENT OF HEALTH AND HUM " SERVICES

PRINTED: 03/16/2016 FORM APPROVED OMB NO 0938-0391

AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) D.	ATE SURVEY OMPLETED
		445383	B. WING	3		2/22/22/4
	N HEALTH AND REH  SUMMARY ST/ (EACH DEFICIENCE		81 M	REET ADDRESS, CITY, STATE, ZIP COI 11 KEYLON STREET ANCHESTER, TN 37355 PROVIDER'S PLAN OF CORR	DE	3/09/2016 (X5)
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE PROPRIATE	COMPLETION DATE
F 514 SS=D	dietary cook and/or revealed walk-in rerusted areas on the observation and intimalk-in refrigerator of the condenser harea above the condender and the door's extered area had an accum. Observation on 3/7 department during service revealed the gasket that was looproper seal.  Interview with the deplate warmer gasket 483.75(I)(1) RES RECORDS-COMPLE  The facility must mare resident in accordant standards and practacurately document systematically organisms. The clinical record information to identify resident's assessm services provided; the preadmission screed and progress notes.	r dietary manager present, frigerators #2, #3 and #4 had a ceiling and walls. Further terview confirmed in the #4 the ceiling area to the right ad a visible gap; the rusted adenser had hanging debris; erior handle and surrounding aulation of sticky debris.  /16 at 6:35 AM in the dietary the resident morning meal e plate warmer lid had a see and failed to maintain a see and failed to maintain a lietary manager on 3/9/16 at any department confirmed the et was in disrepair.  LETE/ACCURATE/ACCESSIB aintain clinical records on each noce with accepted professional stices that are complete; and nized.  must contain sufficient ify the resident; a record of the ents; the plan of care and the results of any ening conducted by the State;	F 456	2. How the facility will identify residents having the potential affected by the same deficient.  All residents have the potential affected.  Refrigerator #2 was permanently out of commission on 3/24/16 at permanently taken out of comm 3/21/16 and both will not be use.  Only one plate warmer serves the and the gasket was ordered on 3 will be replaced by 3/30/16.  Rust remover and paint ordered 3/22/16. Refrigerator #3 will have removed and repainted by 3/30/	to be practice.  to be  y taken nd #4 was ission on ed.  ne facility /24/16 and  on ever rust	4-23-16

AND HUM SERVICES		#7	RINTED: 03/16/2016 FORM APPROVED
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	MB NO. 0938-039 (X3) DATE SURVEY COMPLETED
445383	B. WING	S#	
- ,		TREET ADDRESS, CITY, STATE, ZIP CODE	03/09/2016
	81	11 KEYLON STREET	
Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	RE COMPLETION
dietary manager present, frigerators #2, #3 and #4 had a ceiling and walls. Further erview confirmed in the #4 the ceiling area to the right ad a visible gap; the rusted denser had hanging debris; rior handle and surrounding ulation of sticky debris.  16 at 6:35 AM in the dietary the resident morning meal a plate warmer lid had a see and failed to maintain a see and failed to maintain a see and ince with accepted professional dices that are complete; ated; readily accessible; and nized.  Inust contain sufficient for the plan of care and	F 514	3. What measure will be put in place or systemic changes made to ensure that the deficient practice will not recur.  The Maintenance Director added the interior of the refrigerators and the plate warmer gasket to his monthly rounds inspecting for rust and/or areas of concern effective 3/25/16.  100% of dietary staff have been inserviced on cleaning the kitchen by the Dietary Manager. This will be conducted by 3/22/16. The Dietary Manager will utilize a cleaning schedule and ensure this is being followed. The Dietary Manager will monitor this cleaning schedule 3x/week x 4 weeks, then weekly ongoing to ensure compliance with cleaning schedules.	
	IDENTIFICATION NUMBER:	E & MEDICAL SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445383  AB CENTER  ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)  AGE 3  dietary manager present, frigerators #2, #3 and #4 had eciling and walls. Further erview confirmed in the #4 the ceiling area to the right ad a visible gap; the rusted denser had hanging debris; rior handle and surrounding ulation of sticky debris.  AGE 6:35 AM in the dietary the resident morning meal er plate warmer lid had a see and failed to maintain a see and failed to maintain a  Dietary manager on 3/9/16 at any department confirmed the the was in disrepair.  ETE/ACCURATE/ACCESSIB  AND THE ADMINISTRATION (X2) MULTIPLE ADMIN	CALL   PROVIDER/SUPPLIERCILA   A BUILDING

and progress notes.

This REQUIREMENT is not met as evidenced

DEPAR	TMENT OF HEALTH	AND HUM SERVICES		PR	NTED: 03/16/201
		& MEDICALD SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	OM	FORM APPROVED B NO. 0938-039 X3) DATE SURVEY COMPLETED
		445383	B. WING	. 33	00/00/00 / 5
	PROVIDER OR SUPPLIER  N HEALTH AND REHA	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 811 KEYLON STREET MANCHESTER, TN 37355	03/09/2016
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMPLETION TE DATE
	revealed walk-in refrusted areas on the observation and intervals. In refrigerator of the condenser has area above the condenser has area above the condenser has area above the condenser has area had an accumulate of the door's exters area had an accumulate of the gasket that was loost proper seal.  Interview with the dietal plate warmer gasket 483.75(I)(1) RES RECORDS-COMPLIE  The facility must main resident in accordant standards and practic accurately document systematically organically organically organically organically assessments.	dietary manager present, rigerators #2, #3 and #4 had ceiling and walls. Further erview confirmed in the #4 the ceiling area to the right da visible gap; the rusted denser had hanging debris; ior handle and surrounding ulation of sticky debris.  16 at 6:35 AM in the dietary he resident morning meal plate warmer lid had a se and failed to maintain a set and failed to maintain a etary manager on 3/9/16 at ry department confirmed the was in disrepair.  ETE/ACCURATE/ACCESSIB intain clinical records on each ce with accepted professional ces that are complete; ted; readily accessible; and ized.  But tontain sufficient y the resident; a record of the nts; the plan of care and	F 456	4. How the facility will monitor its corrective actions to ensure the deficient practice is being corrected and will not recur.  The Administrator or Director of Nursing will present the audit results to the monthly Quality Assurance Performance Improvement Committee (Members include: Committee Chairperson — Administrator; Director of Nursing; Assistant Director; Dietary Director; Pharmacy Representative; Social Services Director; Activities Director; Environmental Director/ Safety Representative; Infection Control Representative/Staff Development Coordinator; Rehabilitation Director;	c d

This REQUIREMENT is not met as evidenced

3/21/16

given one on one in-servicing by

CENTE	TMENT OF HEALTI RS FOR MEDICARI	HAND HUM ``I SERVICES E & MEDICA.J SERVICES		PRINTED: 03/16/2016 FORM APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		OMB NO. 0938-0391  NG (X3) DATE SURVEY COMPLETED
		445383	B. WING	*
NAME OF	PROVIDER OR SUPPLIER	- 1	<u>'                                    </u>	STREET ADDRESS, CITY, STATE, ZIP CODE
HORIZO	N HEALTH AND REH.	AB CENTER		811 KEYLON STREET MANCHESTER, TN 37355
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION
F 514	by: Based on facility preview, and interview maintain an accuraneeded medication sampled residents.  The findings include Review of the facility Medication Administrevealed "Policy Smaintain a medication document all medication a minimum:PRN I needed medication: the medication will medical record: The was administered; administrationAny which the drug was achieved and when and The signature a administering the drug Medical record review admitted to the facil including Cellulitis of Weakness, Abnorm of Coordination, Coronary Artery Dis Infection, Hypertens Reflux, and Peripher Medical record reviews Medical rec	colicy review, medical record ew, the facility failed to the medical record for as for 1 (Resident #91) of 27  ed:  ty policy, Documentation of stration, revised on 8/26/15, StatementThe facility shall on administration record to eation administered" Further "Policy Interpretation and ocumentation must include, as as needed] Medication: As the individual administering record in the resident's edate and time the medication. The dosage; The route of complaints or symptoms for administered; Any results those results were observed; and title of the person rug"  ew revealed Resident #91 was ity on 2/19/16 with diagnoses of Right Lower Limb, Muscle ality of Gait and Mobility, Lack ronary Artery Bypass, ease, Recurrent Urinary Tract sion, Gastro Esophageal ral Arterial Disease.  ew of the Physician's Orders ded the following PRN (as	F 51	4.23-16  How the facility will identify other residents having the potential to be affected by the same deficient practice.  All residents have the potential to be affected.  The Director of Nursing completed an audit of all resident charts for PRN (as needed) medication orders on 3/21/16.  Residents who are receiving prn (as needed) medication were reviewed for scheduled pain medication administration on 3/21/16.

DEPARTMENT OF HEALTH AND HUM " SERVICES

## DEPARTMENT OF HEALTH AND HUM SERVICES CENTERS FOR MEDICARE & MEDICAL SERVICES

PRINTED: 03/16/2016 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		445383	B. WING	*	0.0	10010011
	PROVIDER OR SUPPLIER  N HEALTH AND REH	* <u>*</u>	4	STREET ADDRESS, CITY, STATE, ZIP CODE 311 KEYLON STREET MANCHESTER, TN 37355	1 03	/09/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBF	(X5) COMPLETION DATE
F 514	(by mouth) TID (3 2.) Norco (pain metablet po q (every) 3.) Acetaminopher (4 times daily) for following and the following and the following:  Medical record revisite the facility policy of the medication, administering the mafter the administering the mafter the administering the mafter the facility policy of the following:  Medical record revisite facility policy of the medication with the per the facility policy of the medication with the per the facility policy of the MAR Nurse's Mark Nurse'	ciety) 0.5 mg (milligrams) potimes daily). dication) 10 mg-325 mg 1 8 hours. 1325 mg po take 2 tablets QID ever or pain. Director of Nursing (DON) on to 10:30 AM in the ce, when asked if nurses a needed (PRN) medication, the nurses to document and ated the nurses were to initial dication Administration Record ering the medication. Further the back of the MAR was to be PRN medication was lude the date and time, name the dosage, the reason for medication and 30 minutes ation the effectiveness of the extine and initials of the nurse by.  Sew of the 2/2016 MAR and DON on 3/9/16 beginning at ministrator's office confirmed administration on "2/20 x to 12/27 x 2" The back of Medication Notes included the tion/Dosage, Reason, and as: on 2/20 x 1 (although was ministered x 2) and failed to an addressing the x 1 administration; gh was documented as	F 514	3. What measure will be put in por systemic changes made to ethe deficient practice does not recur  The Nurse Educator or Director Nursing will in-service 100% of current licensed nursing staff by 3/21/16 to ensure all PRN (as nemedication consists of the documentation as outlined in the Medication Administration policand procedure to include date, ti dosage, route, site (if applicable) symptoms for which the drug is administered, and results with signature and title of the person administering the drug.  The Director of Nursing will do random audit of 10 residents were x 8 weeks, then biweekly x 4 we then monthly x 1 month for PRN needed) medication administration documentation compliance.	of ceded) ecy me, ), being a ekly eks, I (as	4-23-16

CENTE	RS FOR MEDICARE	AND HUM SERVICES		8	FOR	D: 03/16/201 M APPROVE
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	(X3) DA	O. 0938-039 ATE SURVEY OMPLETED
WAME OF		445383	B. WING		0.	3/09/2016
HORIZO	PROVIDER OR SUPPLIER  N HEALTH AND REHA			STREET ADDRESS, CITY, STATE, ZIP CODE 811 KEYLON STREET MANCHESTER, TN 37355	1 0.	3/03/2016
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BF	COMPLETION DATE
F 514	documentation addr 10:00 AM; and on 2, documentation addr 2.) Norco included a 2/21 x 22/22 x 3, 2 MAR revealed on 2/1 1 administration; on documented as adm to document the effe administration; and documented as adm Medical record revise continued interview beginning at 10:30 A office confirmed the 1.) Xanax included 23/5 x 2, 3/6 x 1 revealed on 3/2 x 1 administered x 2, on effectiveness of the on 3/6 x 2 although administered x 1. 2.) Norco included a 13/3 x 2, 3/4 x 2, 3 MAR revealed on 3/2 effectiveness of the failed to document the AM administration; of effectiveness of the on 3/5 x 2 although administered x 1. 3.) Acetaminophen of administration in I MAR revealed on 3/4	ressing the effectiveness for /27 failed to have ressing the 2 administrations. administration on "2/19 x 1, 2/23 x 3" The back of the 19 no documentation for the x 2/21 x 1 although was ninistered x 2; on 2/22 failed ectiveness for the 7:00 AM on 2/23 x 2 although was ninistered x 3.  We of the 3/2016 MAR and with the DON on 3/9/16 AM in the Administrator's following: administration on "3/2 x ' The back of the MAR although was documented as a 3/5 failed to document the 10:00 AM administration; and was documented as a documented as a documented as a document the 10:00 AM administration; on 3/3 he effectiveness of the 6:00 on 3/4 failed to document the 12:30 AM administration; and was documented as included no documentation March 2016. The back of the 4/16 Acetaminophen (Tylenol) for complaint of a head ache	F 514	4. How the facility will monitor is corrective actions to ensure the deficient practice is being corrand will not recur.  The Administrator or Director of Nursing will present the audit reto the monthly Quality Assurance Performance Improvement Committee (Members include: Committee Chairperson – Administrator; Director of Nursing; Medical Director; Dietary Director Pharmacy Representative; Social Services Director; Activities Director Director of Nursing: Medical Director	e ected  f sults e  ng; or; l ector; lnt ctor; for 4	4-23-16

Continued interview with the DON on 3/9/16

CENTE	TWENT OF HEALTH	HAND HUM " SERVICES			PRINTE	D: 03/16/2016
STATEMEN	RS FOR MEDICARI	E & MEDICAL SERVICES		10 2000	FOR	M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	(X2) MULTIPLE CONSTRUCTION A. BUILDING			
		445383	B. WING			
NAME OF	PROVIDER OR SUPPLIER		- 5	STREET ADDRESS, CITY, STATE, ZIP CODE	03	/09/2016
HORIZO	N HEALTH AND REH		8	11 KEYLON STREET MANCHESTER, TN 37355		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ID DE	(X5) COMPLETION DATE
F 514	beginning at 10:30 office confirmed the policy to accurately	AM in the Administrator's a facility failed to follow the document the number of well as the reason and/or	F 514			4-23-16

DEPARTMENT OF HEALTH AND HUM "I SERVICES